

Registration District No. 101

Primary Registration District No. 5398

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Rural

(c) Name of hospital or institution: None

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Douglas

(c) City or town Rural

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? Siberia (Yes or No)
If yes, name country Douglas

3. (a) PRINT FULL NAME Not named GOTT

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife had none

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 7 29 47 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

3 hr. - min.

9. Birthplace Douglas MO (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

12. Name Edgar F. Gott

13. Birthplace Crossroad MO (City, town, or county) (State or foreign country)

14. Maiden name Edna L. Martin

15. Birthplace Brookfield MO (City, town, or county) (State or foreign country)

16. (a) Informant Edgar F. Gott

(b) Address Crossroad MO

17. (a) Burial (b) Date thereof 7 29 47 (Month) (Day) (Year)

(c) Place: burial or cremation Mills Cemetery

18. (a) Signature of funeral director Messersmith

(b) Address

19. (a) Sept 16-47 (b) Weston Bushman (Day received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29 year 47 hour 7 PM minute M.

21. I hereby certify that I attended the deceased from 7 29 1947 to 7 29 1947; that I last saw her alive on 7 29 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Not known

Duration 7 mo

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 15-9

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) MI

(b) Date of occurrence

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)

While at work? (c) Means of injury

23. Signature M. C. Gentry (M. D. or other) Address via MO Date signed 8.1.47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 1047-1132

Date Filed OCT 28 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.